

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10743 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10738

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Fla.</u> b. COUNTY <u>Hillsborough</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tampa</u> 488-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>3009 Curtis St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Ansel</u> Middle <u>Leonel</u> Last <u>Acosta</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>26</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 20 1922</u> 34 2/3 yrs.
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>Waiter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>	
11. BIRTHPLACE (State or foreign country) <u>Fla.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Joseph Acosta</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Althea Prodie</u> Address <u>3009 Curtis St. Tampa, Fla.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> 82221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>SKULL FRACTURE</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>FRACTURE RIGHT TIBIA & FIBULA</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>WAS THROWN ONTO HIGHWAY WHEN AUTO MOBILE OVERTURNED</u>	
20c. TIME OF INJURY Month, Day, Year <u>5:45 a.m. SEPT 26 1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>US 113 Rd. SUBANVILLE</u>		20f. (City or town) <u>WORCESTER</u> (County) <u>Ind.</u> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Robert C. LaMar</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Robert C. LaMar</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/27/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>		22d. LOCATION (City, town, or county) <u>Tampa</u> (State) <u>Fla.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Hemin</u> ADDRESS <u>Snow Hill, Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 29 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Charles S. House</u>	

DATE SIGNED

9/27/58

WESTLAND STATE DEPARTMENT OF HEALTH - EASTLAND, TX
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE OF DEATH
TIME OF DEATH

[Faint, mostly illegible handwritten text and markings on a medical certificate form. The form includes sections for patient information, medical history, and cause of death.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10739

10750

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Newark</u> c. LENGTH OF STAY IN 1b <u>30 yrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Newark</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Claude</u> Middle <u>S.</u> Last <u>Dwylen</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>2</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 27-1877</u>
9. AGE (In years last birthday) <u>80 1/2</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours	
11. IF UNDER 24 HRS. Min.		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Snow Hill, md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Robert J. Dwylen</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Davis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or date of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Miss Mary E. Dwylen</u>		Address <u>Newark, md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> 260x DUE TO (b) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Diabetes</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19 <u>58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>35</u>		20f. (City or town) <u>Newark</u> (County) (State)	
21. I certify that I attended the deceased from <u>8-31-58</u> to <u>9-2-58</u> , that I last saw the deceased alive on <u>8-31-58</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Berlin, md</u> DATE SIGNED	
ACTUAL SIGNATURE <u>Clifford E. Schott</u> M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Clifford E. Schott</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 4-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Catholic Cemetery</u>		22d. LOCATION (City, town, or county) <u>Snow Hill, md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clayton E. Harris</u> ADDRESS <u>Snow Hill, md</u>		24. REC'D BY REGISTRAR <u>SEP 5 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>		24c. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

0770

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 15 1925		Baltimore, Md.	
Cause of Death		Immediate Cause		Underlying Cause		Manner of Death		Place of Death	
Heart Disease		Myocardial Infarction		Coronary Atherosclerosis		Natural		Home	
Date of Death		Time of Death		Physician's Signature		Physician's Title		Physician's Address	
Jan 20 1970		10:00 AM		J. Smith, M.D.		M.D.		123 Main St., Baltimore, Md.	
Burial or Disposition		Burial		Cremation		Other		Place of Disposition	
Buried		Cremated		Other		Place of Disposition		Cemetery	
Buried		Cremated		Other		Place of Disposition		Cemetery	

10751

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X BERLIN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		1. STREET ADDRESS <u>R.F.D.</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES F. HAGGERTY</u>		4. DATE OF DEATH Month Day Year <u>SEPT 26 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 17, 1878</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ANTIQUE DEALER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN BUSINESS</u>	
11. BIRTHPLACE (State or foreign country) <u>PHILADELPHIA PA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRANCIS HAGGERTY</u>		14. MOTHER'S MAIDEN NAME <u>SARAH MORRIS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war, or dates of service) <u>No</u> <u>No</u>		16. SOCIAL SECURITY NO. <u>1</u>	
17. INFORMANT Address <u>MRS SIDNEY DAVIS, BERLIN MD (RFD)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocarditis</u> <u>431X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertension</u> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-1-</u> <u>56</u> to <u>9-26-58</u> that I last saw the deceased alive on <u>9-23</u> <u>58</u> , and that death occurred at <u>5-30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Berlin Md</u> DATE SIGNED			
ACTUAL SIGNATURE <u>Clifford E. Schott</u> M.D.			
PHYSICIAN'S NAME (Type) <u>CLIFFORD E. SCHOTT</u>		<u>BERLIN MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9-30-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HOLY SEPULCHRE</u>	22d. LOCATION (City, town, or county) (State) <u>PHILADELPHIA PA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna R. Burbage</u> ADDRESS <u>Berlin Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 30 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

HAWAII STATE DEPARTMENT OF HEALTH—BIRMINGHAM-13

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10752

CERTIFICATE OF DEATH

10741

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Newark				c. LENGTH OF STAY IN 1b 12 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION P.O. Box 17				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Newark			
				f. STREET ADDRESS P.O. Box 17			
3. NAME OF DECEASED (Type or print) First Charles Middle T. Last Kennedy				4. DATE OF DEATH Month 9 Day 14 Year 19 58			
5. SEX Male	6. COLOR OR RACE AA C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-17-1894		9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months 11 Days 26	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Utility		10b. KIND OF BUSINESS OR INDUSTRY Hotel		11. BIRTHPLACE (State or foreign country) York, Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Kennedy				14. MOTHER'S MAIDEN NAME Nina Kennedy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) Yes		16. SOCIAL SECURITY NO. 17-19		17. INFORMANT Mrs. Minnie R. Kennedy, Newark, Md., Box 17			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X Cerebral Thrombosis DUE TO right hemiplegia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Essential hypertension DUE TO (c) 				INTERVAL BETWEEN ONSET AND DEATH 7 days about 4 1/2 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 4-7 , 19 54 , to 9-12 , 19 58 , that I last saw the deceased alive on 9-12 , 19 58 , and that death occurred at 12:20 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Coary U. Sully Jr. M.D.				ADDRESS (Street, city or town, state) Berlin, Md.		DATE SIGNED 9/16/58	
PHYSICIAN'S NAME (Type) Dr. I. U. Sully, Jr. M.D.				Berlin, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-18-58		22c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery		22d. LOCATION (City, town, or county) (State) Newark, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart Funeral Home, Salisbury, Md.				24a. REC'D BY REGISTRAR DATE SEP 22 1958		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

10746

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City		c. LENGTH OF STAY IN 1b X Pocomoke City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home		d. STREET ADDRESS 6th	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lloyd Middle Lane Last		4. DATE OF DEATH Month September Day 11 Year 19 58	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 30, 1870
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cement Finisher		10b. KIND OF BUSINESS OR INDUSTRY Vault	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Lane		14. MOTHER'S MAIDEN NAME Maria Robins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Emma Green	
17. INFORMANT Emma Green		Address Pocomoke City, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Ca of Prostate		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/10/58 , 19____, to 9/10/58 , 19____, that I last saw the deceased alive on 9/10/58 , and that death occurred at 7 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Edgar A. J. Whorton M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/14/58	
22c. NAME OF CEMETERY OR CREMATORY Halls Hill Cem.		22d. LOCATION (City, town, or county) (State) Pocomoke City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar Whorton - new Church, Va.		24a. REC'D BY REGISTRAR DATE SEP 16 58	
24b. REGISTRAR'S SIGNATURE William S. Thoms			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 77 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10747

CERTIFICATE OF DEATH

10743

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne City</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Princess Anne</u>				e. STREET ADDRESS <u>100 #1</u>			
3. NAME OF DECEASED (Type or print) First <u>Alfred</u> Middle <u>---</u> Last <u>Pasey</u>				4. DATE OF DEATH Month <u>September</u> Day <u>1</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 22, 1875</u>	
9. AGE (In years last birthday) <u>83</u> yrs		IF UNDER 1 YEAR Months <u>1</u> Days <u>19</u>		IF UNDER 24 HRS Hours <u>58</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seaman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Littleton T. Pasey</u>				14. MOTHER'S MAIDEN NAME <u>Harriett Jane Hudson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>---</u>				16. SOCIAL SECURITY NO. <u>214-28-7972</u>		17. INFORMANT <u>133 N. E. I. I., Inc.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Insufficiency</u> DUE TO <u>Cardiac & Generalized Arteriosclerosis, severe</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>many years</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile Psychosis secondary to (b) above</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Princess Anne</u>	
20f. (City or town) <u>Princess Anne</u>				(County) <u>Worcester</u>		(State) <u>Md</u>	
21. I certify that I attended the deceased from <u>1 Sept.</u> , 19 <u>58</u> , to <u>1 Sept.</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1 Sept.</u> , 19 <u>58</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>N. E. Sartorius, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Pocomoke, Md.</u>			
PHYSICIAN'S NAME (Type) <u>N. E. Sartorius, Jr.</u>				DATE SIGNED <u>9-2-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>9-7-58</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Princess Anne</u>		22d. LOCATION (City, town, or county) (State) <u>Princess Anne, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S. Watson</u>				ADDRESS <u>Princess Anne City, Md</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 5 58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knead</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

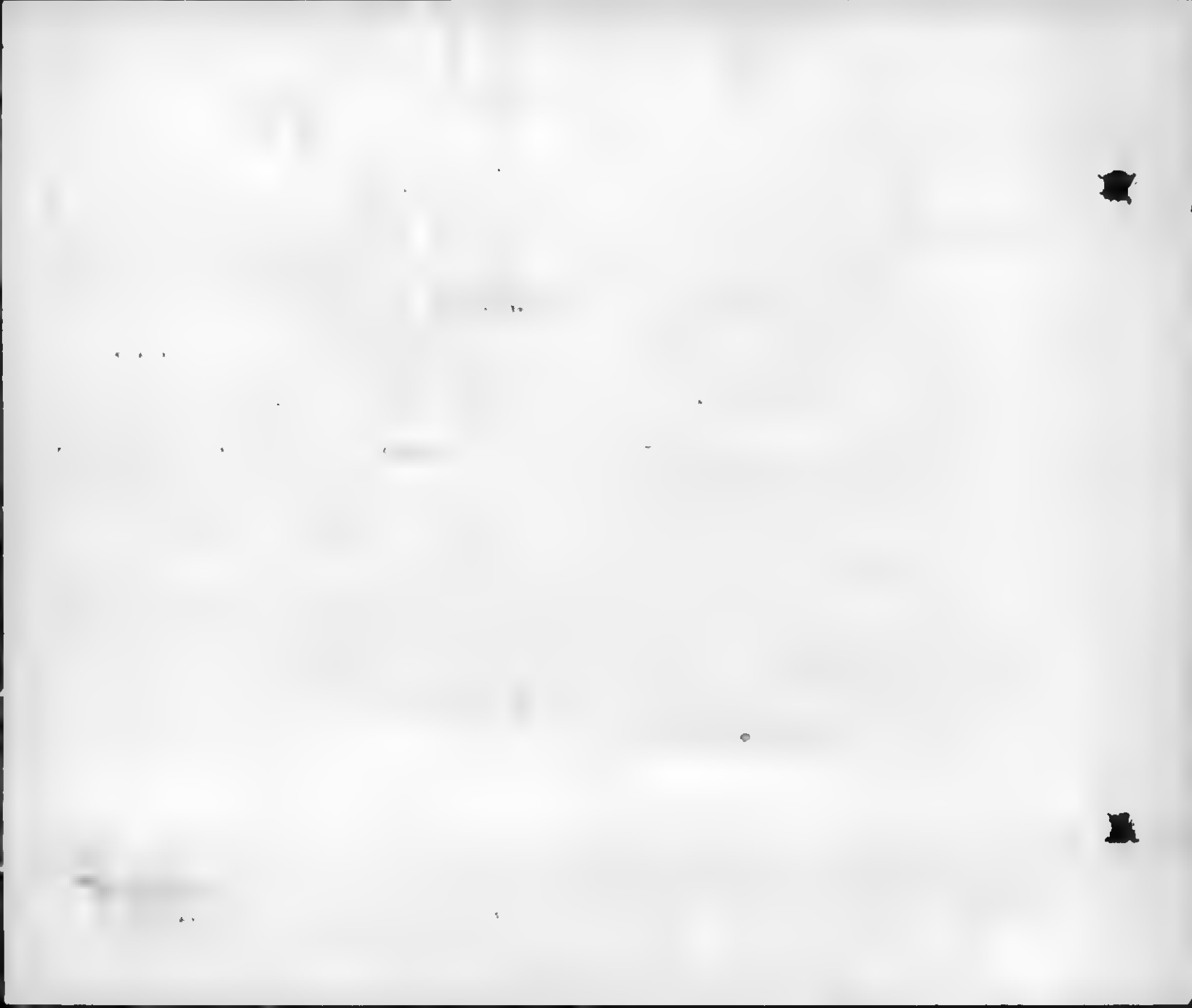
10748

CERTIFICATE OF DEATH

Reg. Dist. No.

10744

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 415 Laurel Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edward Savage		4. DATE OF DEATH September 2 19 58	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 28, 1906
9. AGE (In years last birthday) 51		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Edward Savage Sr.		14. MOTHER'S MAIDEN NAME Mary Lou Sample	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 218-09-3777	
17. INFORMANT Edward Sturgis		Address 508 5th Ave. Pocomoke city, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Atherosclerosis DUE TO Essential Hypertension CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Broncho pneumonia 1 wk		INTERVAL BETWEEN ONSET AND DEATH 15 min 1 yr. 6 mth.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/1/58 , 19 58 , to 9/1/58 , 19 58 , that I last saw the deceased alive on 9/1/58 , 19 58 , and that death occurred at 2 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Cecil A. Duverney M.D.			
PHYSICIAN'S NAME (Type) CECIL A. DUVERNEY			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/6/58	
22c. NAME OF CEMETERY OR CREMATORY Eastville Cem.		22d. LOCATION (City, town, or county) (State) Eastville, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar Wharton - New Church, Va.		24a. REC'D BY REGISTRAR DATE SEP 8 '58	
		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10753

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gordlettsville Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gordlettsville (Rural)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Elton</u> First <u>Lee</u> Middle <u>Snead</u> Last		4. DATE OF DEATH Month <u>Sept</u> Day <u>22</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1915</u> <u>Nov-25-1915</u>
9. AGE (In years last birthday) <u>42 yrs</u>		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>2</u> Hours <u>2</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver - Painting</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Oliver Snead</u>		14. MOTHER'S MAIDEN NAME <u>Clairmont Beckett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-14-8444</u>	
17. INFORMANT <u>Wife</u> <u>Rebelyn Snead</u>		Address <u>Gordlettsville Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>His occupation</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>N. E. Suterius</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>N. E. Suterius</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 25/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Coolspring Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Gordlettsville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas P. Morris, Snow Hill Md</u>		24a. REC'D BY REGISTRAR <u>SEP 24 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10754

CERTIFICATE OF DEATH

10746

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Mercer</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Mercer</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill Rural #2</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill Rural #2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>S.</u> Last <u>Stevens</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>28</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 19-1890</u>
9. AGE (In years last birthday) <u>67 11/19</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Pocomoke City, Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Stevens</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Brittingham</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) <u>No</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>217-36-0786</u>	
17. INFORMANT <u>Mrs Helen B. Stevens, Snow Hill, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC CANCER OF LUNGS</u> DUE TO (ORIGINAL SOURCE UNDETERMINED) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 YR</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1955</u> , 19 <u>58</u> , to <u>Sept 28</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 27</u> , 19 <u>58</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert C La Mar</u>		ADDRESS (Street, city or town, state) <u>104 Bay St Snow Hill, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Robert C La Mar M.D.</u>		DATE SIGNED <u>9/29/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Sept 30/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bates Methodist</u>	22d. LOCATION (City, town, or county) (State) <u>Snow Hill Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clayton D. Davis</u>		24a. REC'D BY REGISTRAR <u>DATE 30 '58</u>	
ADDRESS <u>Snow Hill, Md</u>		24b. REGISTRAR'S SIGNATURE <u>Christina S. Kears</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10755

CERTIFICATE OF DEATH

Reg. Dist. No.

10747

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seebysville, Del. Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Seebysville, Del. - Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Esther</u> First <u>Milbourne</u> Middle <u>Junnell</u> Last		4. DATE OF DEATH <u>Sept.</u> Month <u>16</u> Day <u>1958</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 12, 1915</u>
9. AGE (In years last birthday) <u>43</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Snow Hill, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Theodore Milbourne</u>		14. MOTHER'S MAIDEN NAME <u>Priscilla Waters Milbourne</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Walter Junnell</u> Address <u>Seebysville, Del.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Acute pulmonary edema</u> DUE TO (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Hypertensive Cardio-vascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> <u>7 days</u> <u>4 yrs 8 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-30, 1958</u> , to <u>9/16, 1958</u> , that I last saw the deceased alive on <u>9-16, 1958</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry G. Shelly, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Berlin, Md.</u> DATE SIGNED <u>9/16/58</u>	
PHYSICIAN'S NAME (Type) <u>Ivory V. Sully, Jr.</u>		<u>Berlin, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept. 20</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Wesley</u>	22d. LOCATION (City, town, or county) (State) <u>Snow Hill Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Watson</u>		ADDRESS <u>Pocomoke City, Md.</u>	
24a. REC'D BY REGISTRAR <u>SEP 23 58</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon in papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10756

CERTIFICATE OF DEATH

10748

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1 GRACE ST</u>			
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>EDWARD</u> Last <u>WEST</u>				4. DATE OF DEATH Month <u>SEPT</u> Day <u>5</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 13, 1909</u>	9. AGE (In years last birthday) <u>49</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONTRACTOR</u>		11. BIRTHPLACE (State or foreign country) <u>BERLIN MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM WEST</u>				14. MOTHER'S MAIDEN NAME <u>KATHERINE ARVE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Vol. no. or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-05-0761</u>		17. INFORMANT <u>MRS. J. E. WEST</u>		Address <u>BERLIN MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Apoplexy</u> DUE TO <u>444X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Cardio Vascular Renal Disease, etc</u> DUE TO <u>226X</u> (c) <u>Hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Renal Encephalosis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan</u> 19 <u>56</u> to <u>Sept 5</u> 19 <u>58</u> that I last saw the deceased alive on <u>Apr 5</u> 19 <u>58</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Herman H. Robbins</u> M.D. <u>Berlin, Md</u>							
PHYSICIAN'S NAME (Type) <u>Herman H. Robbins M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/8/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BUCKINGHAM</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burby</u> ADDRESS <u>Berlin Md.</u>				24a. REC'D BY REGISTRAR <u>SEP 9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased</p>		<p>2. Sex</p>	
<p>3. Age</p>		<p>4. Date of birth</p>	
<p>5. Place of birth</p>		<p>6. Date of death</p>	
<p>7. Cause of death</p>		<p>8. Place of death</p>	
<p>9. Signature of physician</p>		<p>10. Signature of registrar</p>	
<p>11. Date of certificate</p>		<p>12. Office of registrar</p>	